

**BOARD OF REGISTERED NURSING**

P O Box 944210, Sacramento, CA 94244-2100

TDD (916) 322-1700

Telephone (916) 322-3350

www.rn.ca.gov



REQUEST FOR TRANSCRIPT PUBLIC HEALTH NURSE CERTIFICATION

A. TO BE COMPLETED BY APPLICANT

Send this form to your baccalaureate school of nursing (BSN). If you need to contact more than one school, this form may be reproduced. Transcripts must include all completed course work and reflect the degree awarded and date conferred. An official transcript must come directly from the school of nursing to the Board of Registered Nursing. Transcripts are not accepted from applicants unless received in a sealed envelope. Your public health training must meet California educational requirements.

NAME: Last		First	Middle	Previous Names (Including Maiden):
ADDRESS: Street		City	State	Zip Code
SOCIAL SECURITY NUMBER:	BIRTHDATE:		TELEPHONE NUMBER:	
	Month Day Year		Home: () Work: ()	
5. NAME OF PROFESSIONAL REGISTERED NURSING SCHOOL:			6. YEARS ATTENDED:	
			_____ to _____	
7. LOCATION: City State (Country)			8. YEAR GRADUATED:	

SIGNATURE OF APPLICANT: _____ DATE: _____

B. TO BE COMPLETED BY THE SCHOOL OF NURSING

The above applicant has applied for Public Health Nurse Certification in California. Please supply the following information and attach an official transcript.

ENTRANCE DATE:	DATE DEGREE REQUIREMENTS MET:	DATE DEGREE AWARDED:

OUT-OF-STATE GRADUATES ONLY

Is this school NLN accredited? Yes _____ No _____ If yes, when: _____

Was the school accredited at the time of applicant's graduation? Yes _____ No _____

SIGNATURE OF OFFICIAL: _____	TELEPHONE: () _____
NAME & TITLE: _____	DATE: _____

SEAL